Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health and Associates

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-14-2310-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are the referring HCP and we are billing for case management services. Please do not deny payment for this service as we are within the medical fee guidelines to bill for this service."

Amount in Dispute: $128.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed the billing and attached documentation, and concluded it does not meet the criteria for the code at (e)(4)(A) of the Rule."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 6, 2013	99361	$28.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for Workers' Compensation Specific Services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions
   - 744 – Does not meet the definition of case management per DWC Rule 134.202 and/or 134.204
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

1. Did the respondent support denial of services?

2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 744 – "Does not meet the definition of case management per DWC Rule 134.202 and/or 134/204." 28 Texas Labor Code §134.204(e)(4) states in pertinent part, "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity." Review of the submitted documentation finds the following;
    a. Case management note dated May 6, 2013 states, "General Purpose: Care Coordination, "Outcome: schedule for individual psychotherapy; establish treatment goals and patient compliance.."

    Review of the submitted documentation finds nothing to support the treating physician participated in the case management service. The carrier's position is supported.

2. The Division finds requirements of Rule §134.204(e)(4) is not met. Therefore, no payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 19, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.